Commonwealth of Massachusetts
Group Insurance Commission

Initial Insurance Enrollment Form
Non-Medicare Retirees/Survivors

TRANSPORTATION

Return completed form to the GIC Coordinator at your Benefits Office. Do not return to the GIC

01 ☐

Insured's GIC-ID (usually Soc. Sec. #)	Sex: Male ☐ Female ☐	Date of Birth	Dept. ID # or Agency/Division #	Check one: ☐ Retiree ☐ Survivor — For Agency Use Only
___ ___		/ /	/	Date of retirement ____/____/____
Name - Last	First	MI		

Address	☐ This is a new address	City	State	Zip Code

Retirees: Do you receive a monthly retirement pension from the MBTA? ☐ Yes ☐ No

Home Phone ( )

02 ☐

BASIC LIFE AND HEALTH COVERAGE

Effective Date: / 01 /

New Enrollment ☐ | Decline Coverage ☐ | Cancel Coverage ☐

☐ **Basic Life and Health** (Select one of the health plans below and individual or family coverage) ☐ **Basic Life Only** Note: Survivors not eligible for Basic Life

Health Plan

- ☐ Fallon Direct (HMO)
- ☐ Fallon Select (HMO)
- ☐ Harvard Pilgrim Independence (PPO)
- ☐ Harvard Pilgrim Primary Choice HMO)
- ☐ Health New England HMO)
- ☐ NHP Care – Neighborhood Health Plan (HMO)
- ☐ Tufts Health Plan Navigator (PPO)
- ☐ Tufts Health Plan Spirit (HMO-type)
- ☐ UniCare State Indemnity/Basic CIC: ☐ Yes ☐ No
- ☐ UniCare/Community Choice (PPO-type)
- ☐ UniCare/PLUS (PPO-type)

☐ Individual
☐ Family

SPOUSE/DEPENDENT INFORMATION

List below all family members, including your spouse or former spouse (if eligible), who will be covered under your health plan. Attach a separate sheet if additional space is required. Please provide all Social Security Numbers (required under Federal Law Section 111) and exact dates of birth for each dependent. To add a dependent age 19 to 26, you must also complete and return to the GIC a Dependent Age 19 to 26 Enrollment Application. **Important:** The Group Insurance Commission requires you to provide a copy of a marriage certificate, birth certificate, certificate of appointment as legal guardian, legal separation agreement, and divorce decree for each person you list as a dependent.

Last Name	First	Middle	Relationship	Date of Birth	Sex	Social Security Number (required)

Effective date: _____

SPOUSE INFORMATION

Is your spouse employed? ☐ Yes ☐ No Name of employer _____ Address of employer _____

Is your spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No Name of insurance company _____

Policy/Certificate Number_____ Address of insurance company_____

Are you and/or your children covered under your spouse's group health insurance plan? You: ☐ Yes ☐ No Children: ☐ Yes ☐ No

Is your spouse enrolled in Medicare? ☐ Yes ☐ No If yes, Medicare claim number_____

FORMER SPOUSE INFORMATION

Name _____ Social Security Number _____ Date of Birth _____ Date of Divorce _____
Last First Middle

Address _____
Street City State Zip Code

Is your former spouse remarried? ☐ Yes ☐ No If yes, date of remarriage _____ Are you remarried? ☐ Yes ☐ No If yes, date of remarriage _____

Is your former spouse employed? ☐ Yes ☐ No Name of employer _____

Is your former spouse covered under his or her employer's group health insurance plan? ☐ Yes ☐ No

SIGNATURE REQUIRED

Deduction Authorization: I authorize my employer, or direct my pension authority, to deduct from my payroll or pension check the amount required for the coverage I have selected.
Health Insurance: I understand that once I choose a health plan, I cannot change plans until the next annual enrollment, even if my doctor or hospital leaves the plan.
Survivors: I am a surviving spouse and certify that I have not remarried and understand that if I do remarry I am no longer eligible for GIC coverage.
Retirees must collect a pension from a public service retirement system to be eligible for GIC coverage.

x _____ x _____
Signature of Applicant Date Signature of Authorized Official Date

FOR GIC USE ONLY:	Entered	Verified	Political Subdivision